S
353.690973
S26rfw
1992

STATE OF MONTANA
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MEDICAID SERVICES DIVISION

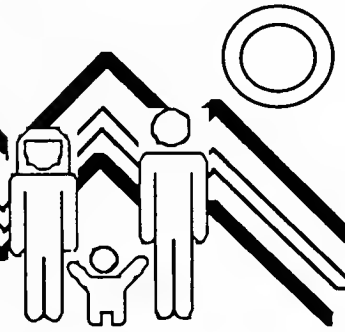
REQUEST FOR WAIVER
UNDER SECTION 1915(b) (1) OF THE
SOCIAL SECURITY ACT
FOR THE
MONTANA PASSPORT TO HEALTH PROGRAM

June 30, 1992

STATE DOCUMENTS COLLECTION

MAY 19 2003

MONTANA STATE LIBRARY
1515 E. 6TH AVE.
HELENA, MONTANA 59



MONTANA DEPARTMENT OF SOCIAL AND REHABILITATION SERVICI
PO BOX 4210
HELENA, MT 59604

MONTANA STATE LIBRARY
3 0864 1001 9521 6

STATE OF MONTANA
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MEDICAID SERVICES DIVISION

REQUEST FOR WAIVER UNDER SECTION 1915(b)(1) OF THE SOCIAL SECURITY ACT

FOR THE

MONTANA PASSPORT TO HEALTH PROGRAM

June 30, 1992

Digitized by the Internet Archive
in 2010 with funding from
Montana State Library

http://www.archive.org/details/requestforwaiver1992unit

A. GENERAL DESCRIPTION OF THE WAIVER PROGRAM

1. The State of Montana requests a waiver under the authority of section 1915(b)(1) of the Social Security Act. The waiver program will be operated directly by the Medicaid agency. This waiver is requested for a period of 2 years effective October 1, 1992 and ending September 30, 1994.

2. The waiver program is called PASSPORT TO HEALTH.

3. The objective of the waiver is to reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to primary care by Medicaid recipients.

4. The basic concept of the waiver is to allow Medicaid recipients to select a primary care physician (PCP) to provide, through an ongoing patient/physician relationship, primary care services and referral for all necessary specialty services. The PCP is responsible for monitoring the health care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under the waiver.

   The PCP will assist the participant in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The PCP will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of recipients enrolled in the waiver program.

   Recipients enrolled under the program will be restricted to receive services included under the waiver either from the chosen or assigned PCP or from another qualified provider to whom the participant was referred by the PCP. The recipient's health care delivery will be managed by the PCP. The waiver's intent is to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care, and efficient, and effective service delivery.

5. The State's waiver program is authorized under Section 1915(b)(1) of the Act, which provides for a primary care case management (PCCM) system or specialty physician services arrangement under which the State restricts the provider from or through whom a recipient can obtain medical care.

   If applicable, the State is also relying upon authority provided in the following section(s) of the Act.

   a. _____ 1915(b)(2) - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

   b. _____ 1915(b)(3) - The State will share cost savings resulting from the use of more cost effective medical care with recipients by providing them with additional services.

   c. _____ 1915(b)(4) - The State requires recipients to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provisions of covered care and services.

6. A waiver is requested of the following sections in 1902 of the Act.

   a. __X__ Section 1902(a)(1) of the Act - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State. The areas included under this waiver are noted in APPENDIX A.7.

b. __X__ Section 1902(a)(10)(B) of the Act - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver includes additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in the waiver program.

c. __X__ Section 1902(a)(23) of the Act - Freedom of Choice--This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, this free choice of providers is restricted. That is, individuals enrolled in this program are constrained to receive primary care from their case manager and have specialty care prior authorized by the PCP.

d. _____ Other (specify)

7. The waiver will be implemented in the following areas of the State.

a. _____ Statewide

b. _____ Only certain cities and counties (cities and counties are listed in APPENDIX A.7.)

c. _____ Only certain rural areas (rural areas are listed in APPENDIX A.7.)

d. __X__ In all areas where enough providers enroll to serve the target PASSPORT recipient population (see APPENDIX A.7. for further clarification).

8. Recipient enrollment in the program will be in accordance with the following.

a. __X__ Enrollment is mandatory, and as a result, those recipients who do not select a PCP will be assigned one (see

d. _____ have to travel more than _____ miles, or _____ minutes to obtain services;

e. __X__ have an eligibility period that is less than 3 months;

f. __X__ live in an area excluded from the waiver;

g. __X__ have an eligibility period that is only retroactive;

h. __X__ have other reasons:
   1) have Third Party Liability (TPL, i.e., another type of insurance in addition to Medicaid) in which they are already enrolled in a managed care program
   2) cannot find a PCP who will accept them;
   3) can prove it would be a hardship to participate;
   4) are in the Medicaid eligibility subgroup of medically needy;
   5) are in the Medicaid eligibility subgroup of subsidized adoption;
   6) are enrolled in the Restricted Card program; and
   7) are receiving Home and Community-Based Waiver services

11. All Medicaid covered services will be included under the waiver with the exception of the following services (please see APPENDIX A.11.).

a. __X__ Dental services

b. __X__ Psychiatry services

c. __X__ Ophthalmology services

d. __X__ Optometry services and eye glasses

e. __X__ Obstetrical services

f. __X__ Pharmacy services

g. __X__ Podiatry services

h. __X__ Nursing home and ICF/MR services

i. __X__ Durable medical equipment

j. __X__ General transportation and ambulance/ wheelchair van services

k. __X__ Other services:
audiology
hearing aid
freestanding dialysis clinic
mental health center
psychologist
licensed clinic social worker
licensed professional counselor
dietitian (EPSDT/HCBW service)
respiratory therapy (EPSDT/HCBW service)
family planning
home and community based waiver
home health
home dialysis attendant
personal care attendant
hospice
anesthesiology
radiology
pathology
lab and x-ray
speech therapy
physical therapy
occupational therapy
private duty nursing
targeted case management

12. In accordance with regulations, preauthorization of emergency and family planning services by the recipient's PCP is not required under the waiver program. Recipients will be informed that emergency and family planning services are not restricted under the waiver. The definition of emergency services is noted in APPENDIX A.12. Also noted is the difference in emergency services with or without the waiver.

13. Services not covered under the waiver will be obtained in the same manner under the regular Medicaid program. Medicaid recipients will be informed of the services not covered under the

waiver and the process for obtaining such services.

14. The chart below lists the types and number of Medicaid providers that qualify to be PCPs under the waiver. Also noted is the number of providers expected to participate after the waiver is implemented. APPENDIX A.14. discloses the types of specialty physicians, clinics or other noted below, if appropriate.

Provider Type	Number of Medicaid Providers Participating Before the Waiver	Number of Medicaid Providers Expected to Participate After the Waiver
1. Physicians	513	535
2. Publicly-funded Clinics	14	14
3. Certified Nurse Practitioners*		
4. Certified Nurse Midwives*		
5. Physician Assistants*		

*See APPENDIX A.14.

15. A limit on the number of recipients which can be enrolled with a PCP will be in effect under the waiver program. A physician PCP will not be allowed to care for more than 1,500 Medicaid recipients him- or herself, plus 1,200 for each physician assistant, certified nurse practitioner, or certified nurse midwife in his/her employ. An independent certified nurse practitioner, physician assistant, or certified nurse midwife PCP will not be allowed to care for more than 1,200 Medicaid recipients. Publicly-funded

clinics will not be allowed to care for more than the sum of the maximum for each full-time equivalent type of primary care providers on its staff. APPENDIX A.15. explains why these limits are consistent with adequate access to care.

16. In accordance with the provider qualifications and requirements under the waiver, PCPs must:

a. __X__ be Medicaid qualified providers and agree to comply with all pertinent Medicaid regulations and State plan standards regarding access to care and quality of services;

b. __X__ sign an agreement or addendum for enrollment as a PCP which explains the PCPs responsibilities;

c. __X__ meet general qualifications for enrollment as a Medicaid provider;

d. __X__ provide comprehensive primary health care services to all eligible Medicaid recipients who choose or are assigned to the PCP's practice;

e. __X__ refer enrollees for specialty care, hospital care, and other services when medically necessary;

f. __X__ authorize services provided by referred providers if it is determined by the PCP that those services are medically necessary;

g. __X__ make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the PCP, a medical professional covering for the PCP, or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours;

h. __X__ not refuse an assignment or disenroll a participant or otherwise discriminate against a participant solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type;

i. __X__ request reassignment of the participant to another PCP only because

(1) __X__ patient/provider relationship is not mutually acceptable

(2) __X__ patient's condition or illness would be better treated by another provider type;

(3) _____ of other reasons (explain)

j. _____ notify the participant in a direct and timely manner of the provider's desire to remove the participant from the providers' caseload;

k. __X__ keep the participant as a client until another PCP is chosen or assigned;

l. __X__ be disenrolled as a PCP as a result of failure to comply with provider requirements;

m. __X__ use the following procedures for referrals

(1) _____ initiate a referral form which the PCP signs

(2) _____ PCPs prepare clinical assessment on referral form

(3) __X__ document referrals in the PCP's files

(4) ___X___ other: verbally arrange referral with another Medicaid provider

n. __X___ approve all non-emergent inpatient admissions;

o. __X___ other qualifications: notify Medicaid in a direct and timely manner of the provider's desire to remove the participant from the providers' caseload; Medicaid will then inform the recipient.

17. Under this waiver, the existing fee-for-service principle is retained and a management fee is paid to the PCP in addition to the regular service fees.

18. PCPs are paid a monthly patient management fee for each eligible participant under their care. The amount of fee paid is

a. __X___ $3.00

b. _____ $1.50

c. _____ 0

d. _____ Other _____

19. The following process is in effect for recipient enrollment under the waiver.

a. The recipient is provided with

(1) ___X___ a brochure explaining the program (see APPENDIX A.19.a.1.);

(2) ___X___ a form for enrollment in the waiver and selection of a PCP;

(3) ___X___ a list of qualified PCPs serving the recipient's geographical area;

(4) _____ other items:

b. __X__ The recipient notifies the State by mail, telephone, or in person of choice of provider.

c. __X__ If the recipient does not choose a PCP, the State assigns the recipient to a provider and notifies the recipient of this assignment (see Appendix A.8.a. for further clarification).

d. __X__ The PCP will be informed by mail or telephone of the participant's enrollment in the program with that provider.

e. __X__ The recipient will be issued a new Medicaid card which includes the PCP's name and telephone number. The PCP information will appear on the next Medicaid card the recipient receives.

f. _____ The recipient will be issued a sticker noting the physician's name and telephone number to be adhered to the Medicaid card.

g. _____ A record will be kept of what special services are offered by PCPs, such as different languages, interpreting services for the deaf, etc. Participants will be advised as to what providers offer any such special services that are needed.

h. _____ The program educational material will be translated into other languages as necessary, such as Spanish.

i. __X__ Providers will be issued forms to assist patients with choice of their PCP.

j. __X__ Every new applicant for Medicaid will be given a brief presentation of receiving primary care and appropriate use of emergency rooms and family planning services under the waiver program as part of the eligibility determination interview.

k. __X__ Other procedures involved in the enrollment process: Montana Medicaid is preparing to issue a Request for Proposals to contract with local entities to help recipients with the enrollment process.

20. The State contact person for this waiver is Sharon Donovan and can be reached by telephone at (406) 444-4540.

B. ACCESS TO CARE AND QUALITY OF SERVICES

1. The State believes that the proposed waiver program does not substantially impair access to services because of the following reasons.

a. __X__ Recipients may choose any of the participating providers in the waiver area as case manager.

b. __X__ The same range and amount of services that are available under the usual Medicaid program are available for waiver enrollees.

c. __X__ Distance and travel time to obtain services for recipients under the waiver will not substantially change from that of the usual Medicaid program.

d. __X__ The number of providers to participate under the waiver compared to before the waiver is expected to remain the same or increase due to the provider incentives offered under the waiver.

e. __X__ Case management, primary care, health education are provided to enrollees by a chosen or assigned PCP. This fosters continuity of care and improved provider/patient relationships.

f. __X__ Preauthorization is precluded for emergency and family planning services under the waiver.

g. __X__ Recipients have the right to change PCPs if the arrangement is not satisfactory.

h. __X__ PCPs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

i. _____ Other:

2. Recipients access to care will be monitored during the waiver period by the State as indicated below. Records will be maintained to identify lack of access trends and for reporting purposes. If a problem is identified, the State will intervene as noted in APPENDIX B.2.

a. _____ An advisory committee with an 800 number will be designated during the phase-in period to address recipients' and PCPs' concerns.

b. __X__ A 24-hour-a-day, 7 days per week Hotline will be maintained which handles any type of inquiry, complaint, or problem. The hotline will be staffed during regular working hours, with an answering machine to take messages the rest of the time.

c. __X__ Periodic comparison of the number and types of Medicaid provider before and after the waiver will be conducted. The intent of this review is to identify whether the waiver may have reduced access to specific types of providers.

d. __X__ Periodic recipient surveys will be mailed to a sample of enrollees which questions recipients' access to all services covered under the waiver. A baseline survey, contained in APPENDIX B.2.d., will be conducted in April, 1992.

e. __X__ PCPs 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours.

f. __X__ The same grievance system which was in effect under the regular Medicaid program will be in effect under the waiver program. Recipients have available a formal appeal process under 42 CFR Part 431, Subpart E which may lead to a Fair Hearing.

g. __X__ The total number of each PCP's enrollees will be monitored to assure PCPs do not enroll more than the State cap authorized.

h. __X__ Other: PASSPORT staff and the contractor for the toll-free hotline will provide an informal grievance process to try to work out problems before they reach the fair hearing process.

3. During monitoring, the State will be reviewing for the following indications to identify access problems.

a. __X__ Long waiting periods to obtain services from a PCP.

b. __X__ Recipients not being referred to specialists when the enrollee believes it to be medically necessary.

c. __X__ Confusion about how to obtain services not covered under the waiver.

d. __X__ Lack of access to services after PCPs regular office hours.

e. __X__ Non-authorized visits to emergency rooms, specialists, etc., for medical care.

f. __X__ Lack of access to emergency or family planning services.

g. __X__ Frequent recipient requests to change a specific PCP.

h. _____ Other indications (explain).

4. To assure quality of services the State's Surveillance Utilization Review System (SURS) will review payment files to identify over/ under recipient utilization and patterns of aberrant PCP behavior. The procedures below will be followed during this review.

   a. Quarterly reports will be generated from the MMIS payment history file in which PCPs will be compared with other PCPs in the following areas.

      (1) __X__ Emergency room visits

      (2) __X__ Physician specialty referrals

      (3) __X__ Inpatient hospitalizations

      (4) _____ Laboratory procedures authorized by a PCP

      (5) _____ Prescriptions filled for a PCP's enrollees

      (6) __X__ Office visits billed by the PCP

      (7) __X__ Total Medicaid expenditures for services billed or authorized by the PCP for its enrollees

      (8) _____ Other (explain)

   b. __X__ PCPs will be mailed summary reports, which compare their performance in the above indicators with other PCPs of their provider type.

   c. __X__ Additional information will be sent and appropriate action taken when the index for PCPs indicator is two standard deviations or another appropriate standard above or below that of comparable providers.

d. ___X___ The PCP will be asked to provide a written explanation of the deviation within a specified period of time.

e. ___X___ If a satisfactory response is not received, the State will take the appropriate intervention(s) as noted in APPENDIX B.2.

f. _____ Other procedures (explain).

5. Quality of services will be further monitored through the mechanisms below. Quality of services complaints identified through the monitoring activities in Items 5.b. through 5.e. will result in a desk review or an on-site medical review to resolve the complaint. Intervention as noted in APPENDIX B.2. will take place if quality of services problems are identified.

a. Periodic medical audits and reported to State medical personnel. Such medical audits will determine whether:

(1) _____ the appropriateness of treatment was consistent with diagnosis;

(2) _____ appropriate treatment and outcomes resulted for participants with certain high risk chronic or acute conditions (e.g., asthma, hypertension, diabetes, otitis media, lead poisoning, drug dependency, diseases preventable by routine immunization);

(3) _____ services provided emphasized preventive care and resulted in early detection;

(4) _____ PCP appropriately referred recipients for specialty care.

(5) _____ other (explain).

b. ___X___ 24-hour-a-day Hotline (staffed during regular working hours, with answering machine available to take messages the rest of the time).

c. ___X___ Periodic recipient surveys mailed to a sample of enrollees which questions the quality of services received under the waiver.

d. ___X___ Grievance system.

e. ___X___ Other (explain).

6. APPENDIX B.6. presents an explanation of the differences in the States procedures to monitor access to care and quality of services before and after the waiver.

C. COST EFFECTIVENESS AND EFFICIENCY

1. Cost effectiveness may be shown by the reducing of costs or a slowing of the rate of increase of costs with the maximizing of outputs or outcome per unit of cost. In order to demonstrate cost effectiveness under this program, this waiver proposal provides a clear comparison, for each year of the waiver project, of what costs are projected to be over the period the waiver is in effect to what costs would be in the absence of the waiver. In this instance, costs under the waiver are less than what costs would be without the waiver in effect.

2. Methodology to Determine Cost Effectiveness of the Waiver

Since this is an initial waiver, the State does not have the use of its waiver program data to demonstrate cost effectiveness. Therefore, the State will must compare its proposed waiver program to another State's PCCM program in effect to demonstrate that enough similarities exists between the two programs to such that it would be reasonable to expect a similar percentage of program cost reductions to occur in its proposed waiver program.

Therefore, the cost effective methodology is shown in steps below and discussed in greater detail in the following sections, in which the State will:

- o Demonstrate the similarities that exist between the comparison of our proposed waiver program and another State's waiver program such that it would be reasonable to expect similar results.

- o Document what our costs are expected to be if the waiver was not implemented.

- o Apply the comparable State's program cost reductions to what our costs are expected to be without the waiver.

- o Document that the total cost reduction (benefit savings) is large enough to offset additional waiver costs such as management fees and administrative costs.

3. Similarities of the State's Proposed Waiver to Another State's Waiver Program

This proposed waiver program is similar to the PCCM waiver program in effect in the State of Michigan . The similarities that exists between these two programs are as follows.

a. __X__ Enrollment is mandatory and recipients may choose any of the participating providers in the State as a case manager or one will be assigned.

b. _____ Enrollment is voluntary and recipients may choose any of the participating providers in the State as a case manager or one will be assigned.

c. __X__ A PCP may be changed at the request of the recipient

(1) _____ with good cause

(2) __X__ without good cause

d. __X__ The type of Medicaid recipients enrolled under the program consist of:

(1) __X__ All Medicaid recipients

(2) _____ Only AFDC and AFDC-related recipients

(3) _____ Only SSI recipients

(4) _____ Other

e. _____ The waiver will be implemented in the following area(s):

(1) _____ Statewide

(2) _____ Urban counties

(3) _____ Rural counties

f. __X__ Case managers must indicate authorization of the referral physician on the Medicaid claim form to assure the appropriateness of the referral.

g. __X__ Computerized edits are used to identify any unauthorized use of physician, emergency rooms, outpatient department, and inpatient care for those recipients who were self-referred.

h. __X__ Claims for unauthorized use of services will be denied.

i. __X__ The existing fee-for-service principle is retained.

j. __X__ The case manager is identified on the recipient's Medicaid card to remind the enrollee whom to contact for care and to inform other providers that giving care not authorized by the case manager may result in unpaid claims.

k. __X__ A fee of $3.00 per member per month is paid to the case manager.

l. _____ Bonus payments from savings generated under the program are paid to case managers who control recipient utilization.

m. _____ Other similarities (explain).

4. Percentage of Cost Reductions

During the 2-year waiver period ended September 30, 1990, the waiver program in Michigan had the following percentage of cost reductions in the noted cost categories.

	AFDC	SSI
a. Physician -	10%	-4%
b. Inpatient -	18%	44%
c. Outpatient -	12%	-44%
d. Pharmacy -	-42%	-27%
e. Laboratory -	10%	-4%

5. Rationale for Expected Cost Reductions

The rationales below apply to the AFDC populations. Please see APPENDIX C.5. for rationale for SSI population.

1) Savings in the proposed waiver program in hospital outpatient services are expected to occur due to a significant decrease in the use of emergency rooms, and some reductions in the use of outpatient clinics, due to restriction to outpatient services only authorized by their case manager.

2) Savings in inpatient services should occur because case managers will approve only those inpatient services that are appropriate and necessary. In addition, improving access to primary care and focusing on preventive services will help avert potentially acute illness.

3) Savings in physician services should occur due to reduced doctor-shopping, improved health status, and less inappropriate referrals to specialty physicians.

4) Pharmacy savings should occur due to reduced doctor-shopping. While pharmacy services do not require the PCP's approval, physician, clinic, and outpatient hospital services do. These are the

main sources of prescriptions, so there is a secondary control on pharmacy services.

5) Reduced laboratory services should occur due to approval of only medically necessary lab work and elimination of duplicate lab tests. While lab and x-ray services do not require the PCP's approval, physician, clinic, and outpatient hospital services do. These are the main sources of lab and x-ray services, so there is a secondary control on these services.

6. Costs Without the Waiver

The State projected what costs would be without the waiver by first calculating the costs during the previous fiscal year (1991) to the waiver period. This base year cost data was then projected forward, adjusting for changes in utilization, characterization of affected recipients, changes in payment rates or methodologies and changes in other State policy, to determine what costs would be without the waiver in effect during the proposed 2-year waiver period. The documentation to demonstrate what costs would be in the absence of the waiver is presented in Exhibit 1.

7. Costs Under the Waiver

a. Total waiver costs are expected to be $199,909,905 during the 2-year waiver period. This includes $195,656,719 in program benefit costs and $4,253,186 in additional costs (management fees, administrative costs, and bonus payments if any, etc.) which would not have been incurred had the waiver not been implemented.

b. Program benefit costs were determined by reducing the costs expected to occur without the waiver by the percentage of cost reductions (savings) which are expected to occur because the program is similar to Michigan's program. Program benefit costs under the waiver were calculated in the following manner.

c. The following schedule shows the calculation of program benefit costs under the waiver.

AFDC AND AFDC-RELATED RECIPIENTS

Cost Category	Costs Expected Without the Waiver (1)	Percentage of Cost Savings (2)	Total Benefit Savings (1) X (2)
Physician	$37,448,023	10%	$ 3,744,802
Inpatient	$73,751,104	18%	$13,275,199
Outpatient	$21,655,104	12%	$ 2,598,613
Pharmacy	$ 6,761,677	-42%	($ 2,839,904)
Lab	$ 482,201	10%	$ 48,220
TOTAL	$140,098,109		$16,826,929

SSI RECIPIENTS

Cost Category	Costs Expected Without the Waiver (1)	Percentage of Cost Savings (2)	Total Benefit Savings (1) X (2)
Physician	$11,713,959	- 4%	($ 468,558)
Inpatient	$27,550,207	44%	$12,122,091
Outpatient	$ 8,523,322	-44%	($ 3,750,262)
Pharmacy	$ 7,538,034	-27%	($ 2,035,269)
Lab	$ 233,089	- 4%	($ 9,324)
TOTAL	$55,558,610		$ 5,858,678

8. Additional Waiver Costs

The following additional costs are expected to occur under the waiver.

a. Management fees of $3,377,367 are expected to be paid under this waiver. The management fees were calculated as follows.

First Year: $3.00 per member per month fee x 448,857 enrollment months = $1,346,571

Second Year: $3.00 per member per month fee x 676,932 enrollment months = $2,030,796

b. Additional administrative costs under the waiver, which would not be incurred if the waiver was not implemented, are expected to be $775,819. Administrative costs are broken down as follows and a brief explanation of each cost item is included in APPENDIX C.8.b.

(1) X Contract Administration $168,612 .

(2) X Systems Modification $252,000 .

(3) X Marketing, Educating Recipients $63,700 .

(4) X Handling Grievances $ 0 .

(5) X Utilization Review System $4,000 .

(6) X Additional Staff $157,295 .

(7) X Other (explain)

a. Hotline operation $102,500 .

b. Quality assurance review $ 0 .

c. Marketing/education providers $ 9,006 .

d. Independent assessment. $ 16,000 .

e. Data processing $30,000 .

c. Bonuses for sharing the savings due to decreased utilization of services with providers are expected to be $_____. The

bonus system and costs calculations are shown on APPENDIX G.

9. Program Savings

The schedule below shows how savings were calculated under the waiver.

Year	Cost Reductions Expected Under The Waiver	Minus: Additional Waiver Costs	Total Program Savings
1993*	$ 7,684,049	$1,941,640	$ 5,742,409
1994*	$15,001,599	$2,311,546	$12,690,013
TOTAL	$22,685,608	$4.253,186	$18,432,422

*Federal fiscal year: Oct. - Sept.

EXHIBITS

AND

APPENDICES

APPENDIX A.7.

GEOGRAPHICAL AREAS UNDER THE WAIVER

The Medicaid program plans to implement the PASSPORT program statewide. However, there may be areas where not enough primary care providers enroll to serve the PASSPORT population of Medicaid recipients.

In many parts of Montana, not just Medicaid recipients but the general population have problems obtaining access to care. Of the 56 counties in Montana, 34 counties or parts of counties are designated as Health Manpower Shortage Areas. Areas with a ratio of primary care provider to PASSPORT recipients that is greater than 1:200 will be monitored carefully by PASSPORT staff to ensure that PASSPORT enrollees will have access to services in their normal health care delivery areas.

Appendix A.9. provides further information on the distribution of primary care providers and the Medicaid population targeted for PASSPORT.

MANDATORY ASSIGNMENT

Step 1. On the fifteenth of each month, TEAMS (the eligibility system) will identify all clients who have not submitted an enrollment form as of the end of the previous month. TEAMS will send these recipients a notice informing the client that if they do not make a selection by the 15th day of the following month, a selection will be made for them.

Step 2. On the 15th day of the following month, TEAMS will generate a report of all clients who have failed to choose a primary care provider. This report will be sent to PASSPORT staff in Medicaid.

Step 3. Medicaid PASSPORT staff will mandatorily assign recipients who fail to choose a primary care provider. Staff will use the following criteria and procedures.

Mandatory Assignment Criteria

1) Residence. The recipient will be assigned to a provider in the recipient's county of residence or an adjacent county. Driving distance to the provider will be minimized to improve access. If the county is broken into zip code blocks, the first test will be against the zip code block, then the county. However, if the assignment is to be made based on historical usage, the test against the zip code block is unnecessary.

2) Historical usage and Grouping of Children. Adults and children will be assigned first to the provider participating in PASSPORT most frequently used in the past twelve months, subject to residence, sex, and age criteria.

3) Age and Provider Type. Any individual may be assigned to a general or family practitioner, family certified nurse practitioner, family physician assistant, or primary care clinic regardless of age. An individual age 17 or younger may be assigned to a pediatrician. An individual 18 or older may be assigned to an internist, adult certified nurse practitioner, or adult physician assistant. A female

who is pregnant may be assigned to an obstetrician or certified nurse midwife.

4) Sex and Provider Type. No male of any age will be assigned to an obstetrician or certified nurse midwife.

Mandatory Assignment Procedures

1) All children in a family will be grouped and assigned to the same provider based on the children's historical usage, or to the provider used most frequently by the child when a family group assignment is inappropriate due to age, sex, or illness factors. No one will be assigned based on historical usage if residence, age, or sex is inappropriate.

2) The recipient zip code block array will be matched against the provider zip code array. When all recipients in all zip code block arrays have been matched against providers in the zip code block arrays to the extent possible, remaining recipients will be assigned using the county-wide recipient and provider arrays.

3) When matching the recipient array against the provider array, each provider in turn will be assigned a recipient before the next provider is eligible to receive an assignment. When an assignment to a provider is made, the next provider on the list becomes eligible for an assignment and the process then repeats.

4) When the recipient/provider match occurs, the assignment will be made as follows:

* when the provider is a general practitioner or family practitioner, all family members will be assigned;

* when the provider is a primary care clinic serving all ages and sexes, all family members will be assigned;

* when the provider is a pediatrician, pediatric nurse practitioner, or pediatric physician assistant, all family members age 17 and younger will be assigned;

* when the provider is an internist, adult certified nurse practitioner, or adult physician assistant, all family members age 18 and older will be assigned; and

* when the provider is an obstetrician or certified nurse practitioner, all pregnant female members age 18 and older will be assigned.

APPENDIX A.8.c.

CHANGE OF PCP

The list below explains the reasons for a change of a PCP under the waiver.

1. Recipients may change PCPs without good cause. Because of the administrative procedures involved in changing PCPs, recipients will be limited to changing PCPs once a month. When recipients ask to change PCPs, PASSPORT or county staff will ask them to volunteer the reason for the change. That reason will be shared with the PCP to provide feedback, and will be used for program evaluation. Recipients who change three times in a six month period will be subject to Department review and may be referred to the Restricted Card program if warranted.

TARGET GROUPS OF RECIPIENTS FOR PASSPORT TO HEALTH

The first two tables below list Medicaid eligibility subgroups that will be targeted for PASSPORT participation and those that will be exempt. They also include the number of recipients in each subgroup as of April, 1992.

The third table delineates the enrollment schedule for the targeted groups.

A. Eligibility subgroups targeted for participation

ELIGIBILITY SUBGROUP	# RECIPIENTS
AFDC	32,829
Automatic newborn	738
Cont. elig. preg. women	1
Extended Med. - child support	24
Ext. Med.-2 mos.-preg. women	142
Foster care - IV-E	745
Foster care - CWS	852
Poverty child	5,260
Poverty child six	5
Poverty pregnant women	1,473
Qualified pregnant women	6
Ribicoff children	71
Transitional Medicaid	3,711
SSI - Aged	1,852
SSI - Blind	75
SSI - Disabled	8,629
TOTAL:	56,413

B. Eligibility subgroups exempt from participation

ELIGIBILITY SUBGROUP	# RECIPIENTS
Subsidized adoption	268
Family medicaid	1,183
Institutionalized aged	3,217
Institutionalized disabled	898
MA aged	686
MA blind	2
MA disabled	875
Other Medicaid	836
Waiver aged	169
Waiver disabled	82
Waiver other	115
TOTAL:	8,331

C. Enrollment schedule.

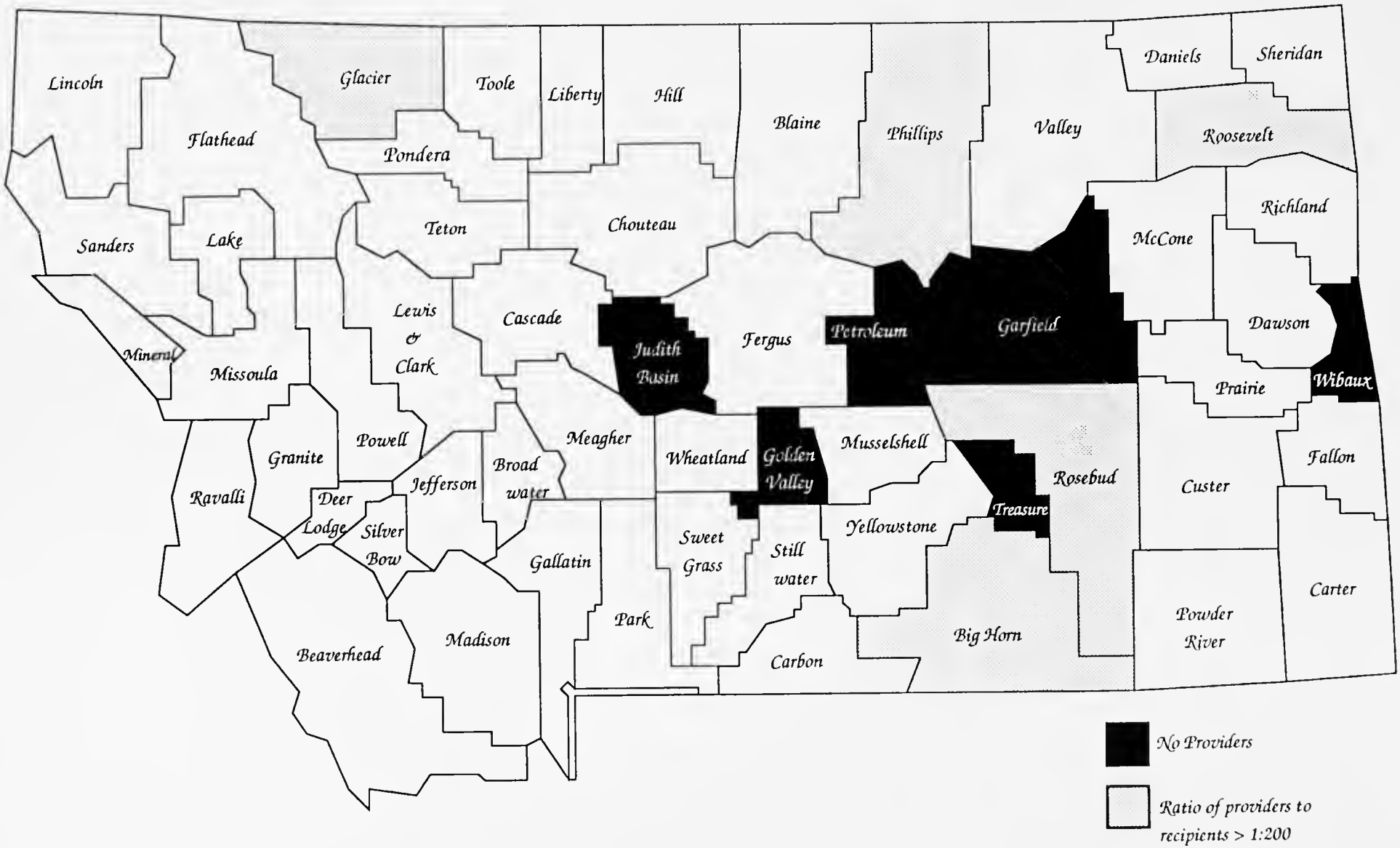
ELIGIBILITY SUBGROUP	WHEN ENROLLMENT WILL BEGIN
Existing AFDC recipients	Mass enrollment: Missoula and Silver Bow counties: October, 1992 Other 54 counties: December, 1992
Existing AFDC-related recipients	Mass enrollment: Missoula and Silver Bow counties: October, 1992 Other 54 counties: December, 1992
New AFDC and AFDC-related recipients	At time of application: Missoula and Silver Bow counties: starting October, 1992 Other 54 counties: December, 1992
Existing SSI recipients	Mass enrollment: July, 1993
New SSI recipients	At time of application, starting July, 1993

PASSPORT TO HEALTH: Ratio of Primary Care Providers to Population 4/9/92

COUNTY	TOTAL				RATIO OF TTL PRV TO:			
	Total Pop.	AFDC	AFDC/ Related	SSI	A FDC	AF DC+ /Rel.	AF DC+ /Rel.+ SSI	Total Pop.
Beaverhead	8,424	285	179	97	1: 36	1: 58	1: 70	1: 1,053
Big Horn	11,337	1,061	241	207	1: 152	1: 186	1: 216	1: 1,620
Blaine	6,728	546	206	160	1: 137	1: 188	1: 228	1: 1,682
Broadwater	3,318	95	99	49	1: 48	1: 97	1: 122	1: 1,659
Carbon	8,080	190	88	104	1: 48	1: 70	1: 96	1: 2,020
Carter	1,503	16	0	0	1: 16	1: 16	1: 16	1: 1,503
Cascade	77,691	3,260	1,234	1,208	1: 43	1: 60	1: 76	1: 1,036
Chouteau	5,542	86	69	37	1: 22	1: 39	1: 48	1: 1,386
Custer	11,697	469	291	231	1: 36	1: 58	1: 76	1: 900
Daniels	2,266	9	0	0	1: 5	1: 5	1: 5	1: 1,133
Dawson	9,505	271	128	59	1: 39	1: 57	1: 65	1: 1,358
Deer Lodge	10,278	615	167	157	1: 88	1: 112	1: 134	1: 1,468
Fallon	3,103	33	63	62	1: 17	1: 48	1: 79	1: 1,552
Fergus	12,083	179	368	284	1: 20	1: 61	1: 92	1: 1,343
Flathead	59,218	2,258	1,015	692	1: 38	1: 55	1: 66	1: 987
Gallatin	50,463	855	597	288	1: 20	1: 35	1: 41	1: 1,202
Garfield	1,589	7	0	0	n/a	n/a	n/a	n/a
Glacier	12,121	1,601	204	277	1: 534	1: 602	1: 694	1: 4,040
Golden Valley	912	17	0	0	n/a	n/a	n/a	n/a
Granite	2,548	64	0	0	1: 64	1: 64	1: 64	1: 2,548
Hill	17,654	1,094	428	242	1: 99	1: 138	1: 160	1: 1,605
Jefferson	7,939	150	62	66	1: 38	1: 53	1: 70	1: 1,985
Judith Basin	2,282	30	0	0	n/a	n/a	n/a	n/a
Lake	21,041	1,545	608	405	1: 77	1: 108	1: 128	1: 1,052
Lewis & Clark	47,495	1,644	760	592	1: 34	1: 50	1: 62	1: 989
Liberty	2,295	19	0	0	1: 6	1: 6	1: 6	1: 765
Lincoln	17,481	953	325	265	1: 79	1: 107	1: 129	1: 1,457
Madison	5,989	96	60	53	1: 19	1: 31	1: 42	1: 1,198

COUNTY	TOTAL				RATIO OF TTL PRV TO:			
	Total Pop.	AFDC	AFDC/ Related	SSI	A FDC	AF DC+ /Rel.	AF DC+ /Rel. + SSI	Total Pop.
McCone	2,276	23	0	0	1: 23	1: 23	1: 23	1: 2,276
Meagher	1,819	46	0	0	1: 46	1: 46	1: 46	1: 1,819
Mineral	3,315	211	0	0	1: 106	1: 106	1: 106	1: 1,658
Missoula	78,687	3,659	1,371	1,263	1: 40	1: 55	1: 68	1: 855
Musselshell	4,106	115	0	0	1: 58	1: 58	1: 58	1: 2,053
Park	14,562	442	228	217	1: 34	1: 52	1: 68	1: 1,120
Petroleum	519	3	0	0	n/a	n/a	n/a	n/a
Phillips	5,163	117	0	0	1: 29	1: 29	1: 29	1: 1,291
Pondera	6,433	284	229	181	1: 57	1: 103	1: 139	1: 1,287
Powder River	2,090	9	0	0	1: 9	1: 9	1: 9	1: 2,090
Powell	6,620	164	112	80	1: 82	1: 138	1: 178	1: 3,310
Prairie	1,383	17	0	0	1: 17	1: 17	1: 17	1: 1,383
Ravalli	25,010	833	429	332	1: 49	1: 74	1: 94	1: 1,471
Richland	10,716	273	146	110	1: 46	1: 70	1: 88	1: 1,786
Roosevelt	10,999	1,210	437	254	1: 151	1: 206	1: 238	1: 1,375
Rosebud	10,505	655	129	149	1: 218	1: 261	1: 311	1: 3,502
Sanders	8,669	409	120	150	1: 82	1: 106	1: 136	1: 1,734
Sheridan	4,732	31	0	0	1: 16	1: 16	1: 16	1: 2,366
Silver Bow	33,941	1,877	611	643	1: 55	1: 73	1: 92	1: 998
Stillwater	6,536	143	99	89	1: 36	1: 61	1: 83	1: 1,634
Sweet Grass	3,154	51	0	0	1: 26	1: 26	1: 26	1: 1,577
Teton	6,271	69	0	0	1: 35	1: 35	1: 35	1: 3,136
Toole	5,046	91	0	0	1: 46	1: 46	1: 46	1: 2,523
Treasure	874	19	0	0	n/a	n/a	n/a	n/a
Valley	8,239	331	224	175	1: 37	1: 62	1: 81	1: 915
Wheatland	2,246	37	0	0	1: 19	1: 19	1: 19	1: 1,123
Wibaux	1,191	29	0	0	n/a	n/a	n/a	n/a
Yellowstone	113,419	4,233	1,701	1,378	1: 36	1: 51	1: 62	1: 969
TOTAL	799,103	32,829	13,028	10,556	1: 48	1: 66	1: 82	1: 1,156

Passport To Health: Provider Shortages



APPENDIX A.11.

PASSPORT-MANAGED SERVICES

REQUIRES PCP AUTHORIZATION	DOES NOT REQUIRE PCP AUTH.
Inpatient Hospital Outpatient Hospital Ambulatory Surgical Centers Physician Federally Qualified Health Center Rural Health Clinic Nurse specialists KIDS COUNT/EPSDT well child screens Admissions to inpatient psychiatric hospitals or residential centers (only under 21) Chiropractic services (only under 21)	Audiology Hearing aid Freestanding dialysis clinic Psychiatrist Mental health services Dietician (an EPSDT service) Respiratory therapy (an EPSDT service) Family planning Home and community based waiver Home health Home dialysis attendant Personal care attendant Hospice Anesthesiology Radiology Pathology Lab and x-ray Speech therapy Physical therapy Occupational therapy Private duty nursing Targeted case management Obstetrical services Nurse anesthetists Rehabilitation (until defined) Dental Transportation and per diem Durable Medical Equipment Outpatient drugs Vision Podiatry Nursing Homes

EMERGENCY SERVICES

A. Emergency services provided under the waiver are defined as follows:

"Emergency services" mean inpatient and outpatient hospital services that are necessary to prevent the death or serious impairment of the health of a recipient.

This definition is contained in 46.12.102 of the Administrative Rules of Montana.

B. The differences in emergency services with and without the waiver are as follows:

The definition of "emergency services" will not be changed when PASSPORT TO HEALTH is implemented.

ADDITIONAL TYPES OF PROVIDERS TO BE PCPS

A. SPECIALTY PHYSICIANS

The following types of specialty physicians may perform as PCPs. Physicians must enroll as individuals; private physician group practices may not enroll as an entity. This parallels the policy on enrolling physicians as Medicaid providers generally. That policy is under review at this time; if it changes to allow private physician group practices to enroll, the PASSPORT policy will change as well.

1. Family practitioners
2. Internists
3. Obstetricians/gynecologists
4. Pediatricians
5. Osteopaths
6. Any other physicians who agrees to provide primary care.

B. CLINICS

The following types of clinics can enroll as PCPs. These are publicly-funded clinics which enroll as a single entity in the Medicaid program generally.

1. Federally Qualified Health Centers (FQHCs)
2. Rural Health Clinics
3. Indian Health Service Clinics on a reservation (Urban IHS clinics provide only a limited range of services and are often open only a few days a week.)
4. Other clinics which meet PASSPORT criteria

C. OTHER

While certified nurse practitioners and certified nurse midwives may practice and bill Medicaid independently in Montana, few do so. One disincentive appears to be the low Medicaid reimbursement nurse practitioners receive: nurse specialists may only be reimbursed 80% of physician fees, which themselves are extremely low. The only exception is for specific pediatric services, where they are reimbursed at the same level as physicians. Certified nurse practitioner participation in this area has been higher.

The 1991 Legislature passed legislation permitting certified nurse practitioners to prescribe drugs. With this new authority, and with the possibility of increasing Medicaid reimbursement by becoming eligible for the PASSPORT case management fee, Medicaid hopes to foster increased participation by this group of providers.

Physician assistants may provide Medicaid services, but at this time may not enroll as an independent Medicaid provider. Montana Medicaid is investigating the possibility of allowing physician assistants to bill directly, and thus have their own Medicaid number instead of having to bill under their supervising physician's Medicaid number. If that change occurs, physician assistants may enroll as PASSPORT providers directly. Under this scenario, Medicaid reimbursement, including the case management fee, would go to the physician assistant's employer, not supervising physician.

Until then, the PASSPORT program will allow physician assitants to serve as primary care providers if the supervising physician, in signing the provider agreement, delegates some or all of the responsibility of being a PCP to the physician assistant. Under the this scenario, the case management fee will be paid to the supervising physician.

PASSPORT TO HEALTH: Distribution of Primary Care Physicians in Montana

4/9/92

COUNTY	FP				INT				PED				OB				TTL DR			
	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P
Beaverhead	1	3	4	75%		3	3	100%	1		1	0%			0	n/a	2	6	8	75%
Big Horn	1	2	3	67%	1	1	2	50%	1		1	0%			0	n/a	3	3	6	50%
Blaine	2	1	3	33%			0	n/a			0	n/a			0	n/a	2	1	3	33%
Broadwater		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Carbon	2	2	4	50%			0	n/a			0	n/a			0	n/a	2	2	4	50%
Carter			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Cascade	9	15	24	63%	4	23	27	85%	1	11	12	92%		12	12	100%	14	61	75	81%
Chouteau	2	2	4	50%			0	n/a			0	n/a			0	n/a	2	2	4	50%
Custer	2	2	4	50%	1	4	5	80%		2	2	100%		2	2	100%	3	10	13	77%
Daniels		1	1	100%		1	1	100%			0	n/a			0	n/a	0	2	2	100%
Dawson	1	4	5	80%		1	1	100%			0	n/a	1		1	0%	2	5	7	71%
Deer Lodge	2	4	6	67%	1	0	1	0%			0	n/a			0	n/a	3	4	7	57%
Fallon		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Fergus	2	5	7	71%		2	2	100%			0	n/a			0	n/a	2	7	9	78%
Flathead	8	25	33	76%	3	13	16	81%	1	4	5	80%		6	6	100%	12	48	60	80%
Gallatin	5	15	20	75%	3	9	12	75%	1	4	5	80%		5	5	100%	9	33	42	79%
Garfield			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Glacier		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Golden Valley			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Granite		1	1	100%			0	n/a			0	n/a			0	n/a	0	1	1	100%
Hill		4	4	100%		4	4	100%		1	1	100%		1	1	100%	0	10	10	100%
Jefferson	1	2	3	67%	1		1	0%			0	n/a			0	n/a	2	2	4	50%
Judith Basin			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Lake	4	14	18	78%			0	n/a	1		1	0%		1	1	100%	5	15	20	75%
Lewis & Clark		17	17	100%	4	13	17	76%	3	7	10	70%		4	4	100%	7	41	48	85%
Liberty		3	3	100%			0	n/a			0	n/a			0	n/a	0	3	3	100%
Lincoln	1	6	7	86%	2	1	3	33%		1	1	100%	1		1	0%	4	8	12	67%
Madison	2	3	5	60%			0	n/a			0	n/a			0	n/a	2	3	5	60%

COUNTY	FP				INT				PED				OB				TTL DR			
	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P
McCone		1	1	100%			0	n/a			0	n/a			0	n/a	0	1	1	100%
Meagher			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Mineral	1		1	0%	1		1	0%			0	n/a			0	n/a	2	0	2	0%
Missoula	9	18	27	67%	10	30	40	75%	1	11	12	92%		13	13	100%	20	72	92	78%
Musselshell	1	1	2	50%			0	n/a			0	n/a			0	n/a	1	1	2	50%
Park	2	2	4	50%	1	4	5	80%		1	1	100%		3	3	100%	3	10	13	77%
Petroleum			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Phillips	2	1	3	33%			0	n/a			0	n/a			0	n/a	2	1	3	33%
Pondera	1	3	4	75%		1	1	100%			0	n/a			0	n/a	1	4	5	80%
Powder River			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Powell		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Prairie		1	1	100%			0	n/a			0	n/a			0	n/a	0	1	1	100%
Ravalli	5	8	13	62%		1	1	100%		1	1	100%	1	1	2	50%	6	11	17	65%
Richland	2	1	3	33%		3	3	100%			0	n/a			0	n/a	2	4	6	67%
Roosevelt	2	1	3	33%		1	1	100%			0	n/a			0	n/a	2	2	4	50%
Rosebud	2		2	0%			0	n/a			0	n/a			0	n/a	2	0	2	0%
Sanders		5	5	100%			0	n/a			0	n/a			0	n/a	0	5	5	100%
Sheridan		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Silver Bow	7	7	14	50%	1	10	11	91%	2	3	5	60%		3	3	100%	10	23	33	70%
Stillwater	1	3	4	75%			0	n/a			0	n/a			0	n/a	1	3	4	75%
Sweet Grass		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Teton		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Toole		2	2	100%			0	n/a			0	n/a			0	n/a	0	2	2	100%
Treasure			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Valley	3	3	6	50%	1	1	2	50%			0	n/a		1	1	100%	4	5	9	56%
Wheatland	1	1	2	50%			0	n/a			0	n/a			0	n/a	1	1	2	50%
Wibaux			0	n/a			0	n/a			0	n/a			0	n/a	0	0	0	n/a
Yellowstone	11	21	32	66%	14	44	58	76%	3	11	14	79%	1	11	12	92%	29	87	116	75%
TOTAL	95	224	319	70%	48	170	218	78%	15	57	72	79%	4	63	67	94%	162	514	676	76%

Note: N/P=Not Participating; P=Participating; TTL=Total; %P=% Participating
Participating=Reimbursed at least $500 by Medicaid in calendar year 1991
Physicians employed by insitutions (eg. IHS, VA, University) not included in tally
Clinics are publicly funded, i.e FQHC, IHS/reservation, and Rural Health Clinics

PASSPORT TO HEALTH: Distribution of primary care providers in Montana 4/9/92

COUNTY	TTL DR				CLINICS				TTL PRV			
	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P
Beaverhead	2	6	8	75%		0	0	n/a	2	6	8	75%
Big Horn	3	3	6	50%		1	1	100%	3	4	7	57%
Blaine	2	1	3	33%		1	1	100%	2	2	4	50%
Broadwater	0	2	2	100%			0	n/a	0	2	2	100%
Carbon	2	2	4	50%			0	n/a	2	2	4	50%
Carter	0	0	0	n/a		1	1	100%	0	1	1	100%
Cascade	14	61	75	81%			0	n/a	14	61	75	81%
Chouteau	2	2	4	50%			0	n/a	2	2	4	50%
Custer	3	10	13	77%			0	n/a	3	10	13	77%
Daniels	0	2	2	100%			0	n/a	0	2	2	100%
Dawson	2	5	7	71%			0	n/a	2	5	7	71%
Deer Lodge	3	4	7	57%			0	n/a	3	4	7	57%
Fallon	0	2	2	100%			0	n/a	0	2	2	100%
Fergus	2	7	9	78%			0	n/a	2	7	9	78%
Flathead	12	48	60	80%			0	n/a	12	48	60	80%
Gallatin	9	33	42	79%			0	n/a	9	33	42	79%
Garfield	0	0	0	n/a			0	n/a	0	0	0	n/a
Glacier	0	2	2	100%		1	1	100%	0	3	3	100%
Golden Valley	0	0	0	n/a			0	n/a	0	0	0	n/a
Granite	0	1	1	100%			0	n/a	0	1	1	100%
Hill	0	10	10	100%		1	1	100%	0	11	11	100%
Jefferson	2	2	4	50%			0	n/a	2	2	4	50%
Judith Basin	0	0	0	n/a			0	n/a	0	0	0	n/a
Lake	5	15	20	75%			0	n/a	5	15	20	75%
Lewis & Clark	7	41	48	85%			0	n/a	7	41	48	85%
Liberty	0	3	3	100%			0	n/a	0	3	3	100%
Lincoln	4	8	12	67%			0	n/a	4	8	12	67%
Madison	2	3	5	60%			0	n/a	2	3	5	60%

COUNTY	TTL DR				CLINICS				TTL PRV			
	N/P	P	TTL	%P	N/P	P	TTL	%P	N/P	P	TTL	%P
McCone	0	1	1	100%			0	n/a	0	1	1	100%
Meagher	0	0	0	n/a		1	1	100%	0	1	1	100%
Mineral	2	0	2	0%			0	n/a	2	0	2	0%
Missoula	20	72	92	78%			0	n/a	20	72	92	78%
Musselshell	1	1	2	50%			0	n/a	1	1	2	50%
Park	3	10	13	77%			0	n/a	3	10	13	77%
Petroleum	0	0	0	n/a			0	n/a	0	0	0	n/a
Phillips	2	1	3	33%		1	1	100%	2	2	4	50%
Pondera	1	4	5	80%			0	n/a	1	4	5	80%
Powder River	0	0	0	n/a		1	1	100%	0	1	1	n/a
Powell	0	2	2	100%			0	n/a	0	2	2	100%
Prairie	0	1	1	100%			0	n/a	0	1	1	100%
Ravalli	6	11	17	65%			0	n/a	6	11	17	65%
Richland	2	4	6	67%			0	n/a	2	4	6	67%
Roosevelt	2	2	4	50%		4	4	100%	2	6	8	75%
Rosebud	2	0	2	0%		1	1	100%	2	1	3	33%
Sanders	0	5	5	100%			0	n/a	0	5	5	100%
Sheridan	0	2	2	100%			0	n/a	0	2	2	100%
Silver Bow	10	23	33	70%		1	1	100%	10	24	34	71%
Stillwater	1	3	4	75%			0	n/a	1	3	4	75%
Sweet Grass	0	2	2	100%			0	n/a	0	2	2	100%
Teton	0	2	2	100%			0	n/a	0	2	2	100%
Toole	0	2	2	100%			0	n/a	0	2	2	100%
Treasure	0	0	0	n/a			0	n/a	0	0	0	n/a
Valley	4	5	9	56%			0	n/a	4	5	9	56%
Wheatland	1	1	2	50%			0	n/a	1	1	2	50%
Wibaux	0	0	0	n/a			0	n/a	0	0	0	n/a
Yellowstone	29	87	116	75%		1	1	100%	29	88	117	75%
TOTAL	162	514	676	76%		15	15	100%	162	529	691	77%

Note: N/P=Not Participating; P=Participating; TTL=Total; %P=% Participating; PRV=Providers
Participating=Reimbursed at least $500 by Medicaid in calendar year 1991
Physicians employed by insitutions (eg. IHS, VA, University) not included in tally
Clinics are publicly funded, i.e FQHC, IHS/reservation, and Rural Health Clinics

APPENDIX A.15.

LIMITS ON THE NUMBER OF RECIPIENTS PER PCP

The following information is provided to explain why the limits established on the number of recipients allowed to be enrolled under each PCP in consistent with adequate access to care.

A limit of 1,500 Medicaid recipients per physician PCP is consistent with the upper limit established by other states currently operating a primary care case management program. It is far in excess of Montana's average ratio of Medicaid recipients to participating primary care physicians.

The limit of 1,200 Medicaid recipients per mid-level practitioner is consistent with the current Medicaid reimbursement schedule for these providers, i.e. they generally are reimbursed 80% of what physicians receive (except for specific pediatric procedures).

TEXT OF RECIPIENT BROCHURE **NOTE: Printing & Graphics will format**

PASSPORT TO HEALTH RULES

1. You must choose a PASSPORT provider from the list of those available in your area. Your PASSPORT provider will be a doctor, clinic, nurse practitioner, or physician assistant who has agreed to help you manage your health care. The list of PASSPORT providers is available at your County Office of Human Services.

2. Once your PASSPORT provider's name appears on your Medicaid card, you must get certain services approved by that person. The list of services that must be approved are in the section called "PASSPORT-Managed Services" on page __. If you get one of those services without your PASSPORT provider's approval, you may be responsible for paying the bill.

3. If you need a PASSPORT-managed service when you are away from your community, you must still get your PASSPORT provider's approval.

4. If you need medical care for a life-threatening emergency, you do not have to get your PASSPORT provider's approval before getting treatment. However, you must notify your PASSPORT provider and get approval after you are treated for the emergency, or you may be responsible for paying the bill.

5. If you move, you may have to change your PASSPORT provider. Check with your County Office of Human Services.

6. If you want to change your PASSPORT provider, you may ask to change as often as once a month. Contact your County Office of Human Services. However, PASSPORT staff will review the requests of those who ask for a change more than three times in a six month period.

If you have questions about your health or medical care, contact your PASSPORT provider.

If you have any questions about how PASSPORT works, call the PASSPORT toll-free hotline at 1-800-******.

TABLE OF CONTENTS

Welcome to PASSPORT

Chapter One - Eligibility and Dates of Coverage

1. Who Must Enroll In PASSPORT
2. How to Enroll In PASSPORT
3. What a PASSPORT Provider Is
4. Selecting Your PASSPORT Provider
5. What You Must Do Once You Are Enrolled
6. The PASSPORT Medicaid Card and Your Responsibility
7. Changing Your PASSPORT Provider
8. If you Move

Chapter Two - How to Obtain Benefits

1. Medicaid Benefits Available Under PASSPORT
2. PASSPORT-Managed Services
3. Services That Don't Need Your PASSPORT Provider's Approval
4. Getting Routine Care
5. Routine Care Away From Home
6. Getting Emergency Care
7. Emergency Care Away From Home
8. Notifying Your PASSPORT Provider of an Emergency

Chapter Three - If You Have Questions

1. About Your Medical Care
2. About How PASSPORT Works
3. About How to File a Complaint

Chapter Four - Responsibilities and Rights

1. Your Responsibilities Under PASSPORT
2. Your PASSPORT Provider's Responsibilities
3. Your Rights Under PASSPORT

Welcome to PASSPORT

PASSPORT TO HEALTH is a new way for you to get health care. The aim is to give you and your family high quality medical care. PASSPORT will replace the current Medicaid program for recipients in certain counties. All the benefits you had under Medicaid are yours with PASSPORT but there are some new features.

This handbook will help you learn about PASSPORT and how it works. Please take time to read it and keep it for review. If you have questions about how PASSPORT works, call the toll-free PASSPORT hotline at ( ).

CHAPTER ONE - ELIGIBILITY AND DATES OF COVERAGE

1. Who Must Enroll in PASSPORT

The Medicaid Services Division will notify you if you are required to enroll in PASSPORT. You will receive this brochure, an enrollment form, and a list of PASSPORT providers in your area.

2. What Is a PASSPORT Provider

A PASSPORT provider is a doctor, nurse practitioner, physician assistant or clinic who has agreed to help Medicaid recipients manage their medical needs.

Your PASSPORT provider will handle your routine medical needs, keep all your medical records up-to-date and in one place, refer you to specialists when needed, and arrange to admit you to a hospital when needed.

You must get certain services directly from or approved by your PASSPORT provider. The section called "PASSPORT-Managed Services" lists what those services are.

3. Selecting Your PASSPORT Provider

When you are notified that you must enroll in PASSPORT, you will be given a list of doctors, nurse practitioners, physician assistants and clinics in your area who have agreed to become PASSPORT providers. You must choose someone from that list. Each person in your household may choose a different PASSPORT provider.

Your enrollment packet will have an enrollment form. When you have filled out in the name of who you want as your PASSPORT provider, please send it to the address listed on the form.

If you do not choose a PASSPORT provider, one will be chosen for you. This either will be a doctor, nurse practitioner, or clinic that you have gone to before or one in your area.

4. What You Must Do Once You Are Enrolled

When the name of your choice of PASSPORT provider appears on your Medicaid card, you must begin getting PASSPORT-managed services directly from or approved by your PASSPORT provider. Those services are listed in the section called "PASSPORT-Managed Services."

Your card will have your PASSPORT provider's name and phone number so you will always know where to go or who to call when you need medical care.

5. The PASSPORT Medicaid Card and Your Responsibility

You **must** show your Medicaid card anytime you get medical care. If you don't, the billing clerk will assume you are no longer Medicaid eligible and will expect you to pay the bill yourself. You should carry your Medicaid card with you at all times so you always have your PASSPORT provider's name, address, and phone number handy.

You should check your Medicaid card each month to make sure the name of your PASSPORT provider is correct on the card. The PASSPORT information on your Medicaid card lets you and your family, your PASSPORT provider, the pharmacy, the hospital, or anyone else who is concerned about your medical needs know that you are covered by PASSPORT.

6. Changing Your PASSPORT Provider

If you want to change your PASSPORT provider, you can call the PASSPORT hotline at ( ) or call your county office of human services. You must choose a new PASSPORT provider from the list of those participating in your area. The change will be effective when your new PASSPORT provider's name appears on your Medicaid card. You may ask to change your PASSPORT provider once a month. However, frequent requests to change may be reviewed by PASSPORT program staff.

7. If you Move

If you move, you may need to choose a new PASSPORT provider. Most changes can be handled by telephone. Please call your county office of human services right away so your card will be mailed to the right address. Your county office will need to verify your new address.

CHAPTER TWO - HOW TO GET MEDICAL CARE

1. Medicaid Benefits Available Under PASSPORT

Under PASSPORT, your are eligible to receive the same range of benefits as before. However, your PASSPORT provider <u>must</u> approve the services listed in the section called "PASSPORT-Managed Services" or you may be responsible to pay the bill.

2. PASSPORT-Managed Services

Once the name of your PASSPORT provider appears on your Medicaid card, she or he must approve the services listed below or you may be responsible to pay the bill.

Services	PASSPORT Provider Authorization Required
Ambulatory Surgical Centers (outpatient surgery)	Yes
Inpatient Hospital	Yes
Outpatient Hospital	Yes
Emergency Room	Yes
KIDS COUNT/well-child visits	Yes
Physician Office Visits	Yes
Public Clinics (including IHS)	Yes
Nurse Practitioner	Yes
Chiropractor (for under 21)	Yes

There are some exceptions; see the next section for services that you may get without checking with your PASSPORT provider.

3. Services That Don't Need Your PASSPORT Provider's Approval

If a Medicaid service is not listed in the section called "PASSPORT-Managed Services," you do not need your PASSPORT provider's approval to get it. Here is a list of some of the services you do not need your PASSPORT provider's approval for:

Services You May Get **WITHOUT** Your PASSPORT Provider's Approval:

Dental services
Family planning
Hearing services
Home health
Hospice
Mental health
Obstetrical (pregnancy-related) services
Occupational Therapy
Physical Therapy
Speech Therapy
Vision services

4. Getting Routine Medical Care

Your PASSPORT provider will handle all of your routine medical care. She or he will also refer you to a specialist or arrange for you to go into the hospital if needed. To see your PASSPORT provider, call ahead to make an appointment.

5. Routine Care Away from Home

Routine or follow-up care you get when away from home will not be covered unless your PASSPORT provider approves it first.

6. Getting Emergency Care

Care for medical problems that are an emergency is fully covered 24 hours a day, 7 days a week. It is important that you follow certain steps when emergency care is needed. The action you should take in an emergency depends upon how serious it is:

Life Threatening If a serious emergency occurs, go directly to the nearest emergency room or immediately phone an ambulance. Show them your Medicaid card and you will be treated. The emergency room will call your PASSPORT provider as soon as possible. The name and phone number of your PASSPORT provider is on your PASSPORT card. Your PASSPORT provider can give advice to emergency room personnel for treating your emergency and will handle your follow-up care.

A life threatening emergency is the sudden onset of a condition that could endanger your life or cause lasting damage if not treated right away. Examples of life-threatening emergencies are: serious accident, heart attack or stroke, severe shortness of breath, chest pain, poisoning, severe cuts or burns, damage to your eyes, convulsions, severe bleeding or wounds, broken bones, miscarriage, going into labor, or any other sudden onset of a condition which could endanger your life or cause permanent disability if not treated immediately. [pediatric examples will be added]

Non-Life Threatening If it isn't a life-threatening emergency (for example: sore throat, flu, back pain, frequent urination, tension headache [pediatric examples will be added), you should call your PASSPORT provider's office for advice. The phone number is on your Medicaid card. Your PASSPORT provider will tell you how to handle the situation, no matter what time of day it is, 7 days a week. Your PASSPORT provider will tell you to come to the office or clinic or to go to the hospital emergency room.

7. Emergency Care Away from Home

In case of a serious emergency away from home, go to the nearest emergency room. Have the person on duty call your PASSPORT provider within 24 hours or as soon as possible. If you are admitted to a hospital away from home, have someone call your PASSPORT provider as soon as possible.

8. Notifying your PASSPORT Provider of an Emergency

Your PASSPORT provider must authorize all emergency room visits. Visits for life-threatening emergencies do not have to be approved before going to the emergency room; they can be approved after the

emergency room takes care of the life-threatening emergency.

In any kind of an emergency - at home or away - it is important for your PASSPORT provider to learn about it as soon as possible so that he or she can share your medical history with the person treating your emergency. If you are given emergency room treatment or are admitted to a hospital for an emergency, make sure that someone - you, a family member or the hospital - contacts your PASSPORT provider within 24 hours or as soon as possible.

CHAPTER THREE - IF YOU HAVE QUESTIONS

1. About Your Medical Care

If you have a question about your medical care, ask your PASSPORT provider. It's important you understand your medical condition and what your PASSPORT provider recommends you do about it.

2. About How PASSPORT Works

If you have a question about how the PASSPORT TO HEALTH program works, call the PASSPORT toll-free hotline at 1-800- .

3. About How to File a Complaint

If you have a problem that cannot be solved to your satisfaction, you can file a complaint with the PASSPORT office. All complaints are recorded and action is taken to solve them right away.

There are two ways you may file a complaint. You can call the toll-free PASSPORT hotline at ( ). You may also write down your complaint and send it to: PASSPORT Program, SRS/Medicaid, PO Box 4210, Helena, MT 59604. Your complaint will be reviewed and the outcome will be sent to you in writing.

Contact the PASSPORT hotline if you have any questions about filing a complaint.

CHAPTER FOUR - YOUR RESPONSIBILITIES AND RIGHTS

1. Your Responsibilities:

1. Take your Medicaid card when you go get medical care and show it to the billing clerk.
2. Keep appointments. Be on time. Try to call your PASSPORT provider when you are going to be late or can't keep the appointment.
3. Treat your PASSPORT provider and his or her staff with respect.
4. Fully inform your PASSPORT provider of your medical problems and ask questions.
5. Decide about having a treatment or procedure before it is done.
6. Consider what may happen if you refuse the treatment your

PASSPORT provider advises.
7. Help your PASSPORT provider get your previous medical records or fill out new ones.
8. Get your PASSPORT provider's approval before you get a service listed in the section called "PASSPORT-Managed Services."
9. State your complaints, concerns and opinions in a polite way.
10. Follow PASSPORT rules.

2. Your PASSPORT Provider's Responsibilities:

1. Provide primary care and arrange for you to see specialists when needed.
2. Provide or arrange for coverage of services 24-hours a day, seven days a week.
3. Provide or arrange for Kids Count well-child visits for children under 21.
4. Not use discriminatory practices with PASSPORT patients such as separate waiting rooms, separate appointment days, or preference to private pay patients.

3. Your Rights:

1. Be treated politely and with respect by your PASSPORT provider and their staff.
2. Understand your illness.
3. Be told about the treatment your PASSPORT provider advises before it is done.
4. Refuse treatment to the extent of the law and to be told of the outcome.
5. Talk to your PASSPORT provider and expect that your records and conversations will be kept confidential.
6. Choose your own health care provider or clinic. If you do not choose one yourself, one will be chosen for you.
8. Make a complaint about PASSPORT and receive an answer.
9. Understand how the PASSPORT program works.
10. Know what medical services are covered by PASSPORT and Medicaid.

[added to the end of the brochure will be schedule for well-child visits and immunizations and adult preventive screening schedules]

APPENDIX B.2.

TYPES OF STATE INTERVENTIONS

The following types of State interventions will be conducted to resolve access to care and quality of services problems.

1.	X	Education and informal mailing
2.	X	Telephone and/or mail queries and follow-up
3.	X	Request PCP response to identified problems
4.	X	Warning letters
5.	X	Referral for further investigation
6.	X	Referral to State's medical staff for review and investigation
7.	X	Corrective action plans and follow-up
8.	X	Change recipient's PCP
9.	X	Restriction on types of recipients
10.	X	Further limits of the number of assignments
11.	X	Ban on new assignment
12.	X	Transfer of some or all assignments to a different PCP
13.	X	Suspension or termination as a PCP
14.		Suspension or termination as a Medicaid provider
15.		Other _____

SURVEY OF MEDICAID RECIPIENTS' ACCESS TO HEALTH CARE

1. Age: _____ years 2. Sex: /__/ Female /__/ Male

3. Are you a single parent? /__/ Yes /__/ No

4. How many children under 18 live with you? _____

5. What is your zip code? _____

6. How long have you lived in the county you are in now? ___ Years ___ Months

7. How long (total time) have you been on Medicaid? ___Years ___Months

8. Do you have a family or personal doctor?

/__/ Yes /__/ No

a. If yes, was this person also your doctor before you got on Medicaid?

/__/ Yes /__/ No

9. When you need routine medical care, how quickly can you usually get an appointment with a doctor or clinic?

___1. Within one day
___2. Within one week
___3. Within two weeks
___4. Over two weeks
___5. Other (please explain) _____

10. Once you show up for an appointment, how long do you usually have to wait before you actually see a doctor/nurse/physician assistant?

___1. Under 5 minutes
___2. Up to 10 minutes
___3. Up to 20 minutes
___4. Up to 30 minutes
___5. Up to an hour
___6. Over an hour

11. Have you ever been very sick and had a problem getting an appointment with a doctor or clinic within two days?

/__/ Yes /__/ No

a. If yes, do they help you find another place to go?

/__/ Yes /__/ No

b. If yes, where do they refer you to?

___1. Another doctor's office
___2. Public health clinic or community health center
___3. Emergency room at the hospital
___4. Other (please specify)_____

12. Have you ever felt that a clinic or doctor's office has refused to give you an appointment because you have Medicaid?

/__/ Yes /__/ No

13. Are any of the following reasons you do **NOT** get medical care when you need it? (Please check all that apply)

___1. Lack of transportation
___2. No child care
___3. Long waiting list for appointment
___4. Can't get appointment
___5. Had to wait too long at the clinic/doctor's office
___6. Can't get time off from work
___7. Don't know where to go
___8. Doctor/clinic was not taking any new patients
___9. Doctor/clinic was not taking any new Medicaid patients
___10. Don't like doctors and hospitals
___11. Scared of doctors and hospitals
___12. Can't pay the Medicaid copayment
___13. Don't know what Medicaid does or does not cover
___14. Uncomfortable about telling doctor's office that Medicaid is my insurance
___15. People in the clinic/doctor's office were not nice to me
___16. Other (please explain)_____

14. When you go to the doctor, do you carry out the follow-up instructions (eg. drugs, another appointment, etc.) that the doctor recommends?

/___/ Yes /___/ No /___/ Sometimes

a. If not, why not?

___1. Don't understand instructions
___2. Can't pay copayment
___3. Medicaid doesn't cover what I was supposed to do
___4. No transportation
___5. Don't agree with treatment
___6. Other (please explain)_____

15. How far from your home (one way) do you generally go to get medical care?
_____ Miles

16. How far from your home (one way) is the nearest pharmacy that accepts Medicaid?
_____ Miles

a. What hours is it open? (check all that apply)
___ 1. 24 hours a day
___ 2. During the day
___ 3. During evenings
___ 4. Saturday
___ 5. Sunday
___ 6. Don't know

17. Is there a pharmacy that's closer but doesn't accept Medicaid? /___/Yes /___/No

18. Have you had a prescription filled at a pharmacy in the past year?

/___/ Yes /___/No

a. If yes, how do you get there?
___ 1. Bus
___ 2. Taxicab
___ 3. Walk
___ 4. Have it delivered
___ 5. Your own vehicle
___ 6. Other _____

b. Have you had problems getting a prescription filled because you had to pay a copayment?
/___/ Yes /___/ No

c. What is the average amount of drug copayments you pay **EACH** month?

___1. $1-10 ___2. $11-20 ___3. $21-50 ___4. $50+

19. If you are a woman, have you been pregnant during the last year?

/___/ Yes /___/ No /___/ Doesn't apply

[If you checked "No" or "Doesn't apply", please go to question 20.]

a. If yes, how many months pregnant were you when you began going for pregnancy check-ups?

___ Months
___ Don't know

b. How easy or difficult was it to find a nurse midwife, doctor, or clinic to provide care during your pregnancy?

___1. Easy
___2. Somewhat easy
___3. Somewhat difficult
___4. Difficult
___5. Couldn't find anyone
___6. Did not seek care before delivery

c. Women sometimes have problems getting check-ups while pregnant. Were any of these a problem for you? (Please check all that apply to you)

___1. Lack of transportation
___2. No child care
___3. Long waiting list for appointment
___4. Can't get appointment
___5. Had to wait too long at the clinic/doctor's office
___6. Can't get time off from work
___7. Don't know where to go
___8. Doctor/clinic was not taking any new patients
___9. Doctor/clinic was not taking any new Medicaid patients
___10. Don't like doctors and hospitals
___11. Scared of doctors and hospitals
___12. Didn't want my family to know I was pregnant
___13. Can't pay the Medicaid copayment
___14. Don't know what Medicaid does or does not cover
___15. Uncomfortable about telling doctor's office that Medicaid is my insurance
___16. People in the clinic/doctor's office were not nice to me
___17. Other (please explain)_____

20. Do your children have a family or personal doctor?

/___/ Yes /___/ No

b. Was this person their doctor before they got on Medicaid?

/___/ Yes /___/ No

21. Do your children get regular "well-child" visits? (In well-child visits, doctors check children's progress, give shots such as measles vaccine, and do routine physical exams to try and catch medical problems before they become serious.)

/___/ Yes /___/ No

a. If no, please check if any of the reasons below apply.

___ 1. Child(ren) don't have regular doctor
___ 2. Cannot find doctor, nurse, or clinic that will do this
___ 3. No transportation
___ 4. Only take child to doctor when sick
___ 5. Other (please explain)_____

22. How often have you or your family been to the emergency room in the last year?

___1. Never
___2. Once
___3. Twice
___4. Three times
___5. Four times
___6. Every month
___7. Other (please explain)_____

a. If you or your family have gone to the emergency room in the last year, please check below all that reasons apply:

___1. Serious injury or illness that needed immediate attention
___2. Tried but could not get an appointment at a doctor's office or clinic
___3. Most convenient place to get medical care
___4. Other (please explain)_____

23. From the list below, which are the best ways we can let you know about changes in Medicaid benefits? (Please check all that apply)

___1. County eligibility worker
___2. Mail
___3. Announcement in the newspaper
___4. Pamphlet
___5. Poster
___6. Television
___7. Radio
___8. Meetings
___9. Enclose notice with monthly Medicaid card
___10. Other (please explain)_____

24. Do you have any additional comments on Medicaid?

Return to: Dept. of SRS, Medicaid Services Division, P.O. Box 4210, Helena, MT 59604

APPENDIX B.6.

PROCEDURES TO MONITOR ACCESS TO CARE AND QUALITY OF SERVICES

The following information is provided to explain the differences between the State's procedures to monitor access to care and quality of services before and after the waiver.

Currently, i.e. prior to the PASSPORT program, the SURS unit generates quarterly reports to identify overutilization of services. They also examine a random sample of claims to see if the treatment was appropriate to diagnosis. In addition, Medicaid has developed a criteria file which has been incorporated into the claims processing system. This criteria file applies to claims filed by physicians, podiatrists, and nurse specialists.

Under the waiver, the above procedures will continue to be performed. In addition, the SURS quarterly reports will be examined for underutilization as well as overutilization. The toll-free hotline will provide a way to monitor complaints and grievances. Finally, recipients will be surveyed periodically to monitor their access to care and perceptions of the quality of care they receive.

APPENDIX C.5.

RATIONALE FOR SAVINGS FOR SSI POPULATION

1) Increases in the proposed waiver program in hospital outpatient services are expected because of substitution of more cost effective outpatient services for inpatient, especially in the area of mental health.

2) Savings in the proposed waiver program in hospital inpatient services are expected because of a shift of care to the more cost effective outpatient setting, shorter lengths of stay, a reduction in intensity of care, and fewer admissions. These are expected because improving access to care and continuity of care for this population, which has complex medical needs, should reduce acute episodes of illnesses or conditions.

Michigan's cost savings experience in this category was 62%. However, their SSI population is enrolled primarily through physicians offices or if they are overutilizers. This suggests they are higher users of services than SSI recipients not enrolled in Michigan's primary care case management program. When they excluded mental health admissions, they arrived at a more conservative rate of 44%. Montana will use this conservative savings rate in its estimate.

3) Increases in the proposed waiver program in physician services should occur due to improved access and the concomitant emphasis on emphasis on prevention and outpatient care.

4) Increases in the proposed waiver program in pharmacy services should occur due to the general trend of increased ambulatory costs offset by reduced inpatient costs.

5) Increases in the proposed waiver program in laboratory services should occur due to the general trend of increased ambulatory costs offset by reduced inpatient costs.

APPENDIX C.8.b.

ADDITIONAL ADMINISTRATIVE COSTS

The following information is provided to explain the additional administrative costs expected to incur under the waiver.

1. Contract Administration.
   Right now, recipients are told little about the Medicaid program when they become eligible for it. Eligibility specialists in the county human service offices do not have the time to describe it in detail. The application process is often overwhelming, with numerous programs being explained in one sitting. To remedy this, and to enhance the success of PASSPORT TO HEALTH, the Medicaid program will contract will local entities to do Medicaid/PASSPORT outreach.

   These entities will contact recipients mandated to participate in PASSPORT, as well as new Medicaid recipients, and encourage them to attend an orientation meeting. In this meeting, both PASSPORT specifically and Medicaid generally will be explained, questions answered, and guidance provided in choosing PASSPORT providers.

2. Systems modifications.
   The PASSPORT program will be monitored through computer edits on MMIS, the claims processing system. This is a significant enhancement. The current estimate for this systems enhancement is $250,000.

   Eligibility is tracked by a different system called TEAMS (The Economic Assistance Management System). PASSPORT enhancements to this system are also considerable, but because of the terms of the contract governing operation of TEAMS, there will be no additional costs.

3. Marketing, Educating Recipients.
In addition to the marketing/educating mentioned in Item #1 above (Contract Administration), the Medicaid program will develop an informational video for recipients and a brochure explaining PASSPORT. The bulk of recipients will be enrolled by mail. Health education material will be incorporated into a calendar the Department currently devotes to home energy. The Medicaid contribution to this calendar will cover the cost of increasing the size of the calendar and the number of recipients who receive it. Below is a breakdown of these costs:

Video:	$1,000
Brochure:	$5,200
Mailing:	$39,500
Calendar:	+ $18,000
	$63,700

4. Handling grievances.
This will be handled by PASSPORT staff as part of the administration of the program. No separate costs will be incurred.

5. Utilization review.
This function will be part of the upcoming utilization review Request for Proposals. The future contractor will be responsible for reviewing quarterly reports on PASSPORT providers' performance and determining the cause for providers who consistently are ±2 standard deviations from the norm.

6. Additional staff.
Two staff will be devoted to this project. One staffperson has spent 12 months developing PASSPORT prior to the waiver period and will be responsible for implementing and operating it. A second staffperson will be hired in the second year of the waiver to assist with program management. Salary includes benefits.

7. Hotline operation.
The toll-free PASSPORT hotline will be contracted out.

8. Quality assurance review. None, as this will not be conducted during the first waiver period.

9. Marketing/education providers.
The costs associated with recruiting and educating providers are a factsheet used during initial marketing, a brochure to be developed once the program starts, travel to explain the program and solicit suggestions, and postage for enrollment packets.

10. Other.

a) Independent assessment. An independent assessment of the impact of PASSPORT on access to care, quality of care, and cost-effectiveness must be submitted to HCFA 6 months before the waiver renewal.

b) Data processing. Information must be extracted from the paid claims database to monitor utilization and cost effectiveness. The Medicaid program must pay for the time spent running tapes on the mainframe.

ADDITIONAL ADMINISTRATIVE COSTS

APPENDIX C.8.b.

	Prior to waiver	1st year of waiver	Prior + 1st year	2nd Year of waiver	TOTAL
Contract administration	$0	$84,306	$84,306	$84,306	$168,612
Systems modifications	$250,000	$1,000	$251,000	$1,000	$252,000
Marketing, ed. recip.					$0
brochure	$5,200	$0	$5,200	$0	$5,200
video	$0	$1,000	$1,000	$0	$1,000
mailing (1.58x25,000)	$0	$39,500	$39,500	$0	$39,500
calendar	$0	$0	$0	$18,000	$18,000
TOTAL	$5,200	$40,500	$45,700	$18,000	$63,700
Handling grievances	$0	$0	$0	$0	$0
Utilization review		$2,000	$2,000	$2,000	$4,000
Additional Staff					$0
Salary (1st person)	$35,232	$32,522	$67,754	$32,522	$100,276
Salary (second person)	$0	$8,131	$8,131	$32,522	$40,653
Equipment (1st person)	$4,000	$0	$4,000	$0	$4,000
Equipment (2nd person)	$0	$1,000	$1,000	$4,000	$5,000
Operations (1st person)	$1,842	$1,700	$3,542	$1,700	$5,242
Operations (2nd person)	$0	$425	$425	$1,700	$2,125
TOTAL	$41,074	$43,778	$84,851	$72,444	$157,295
Hotline operation	$10,000	$42,500	$52,500	$50,000	$102,500
Marketing, ed. providers					$0
factsheet	$200	$0	$200	$0	$200
brochure	$1,200	$0	$1,200	$0	$1,200
travel	$2,500	$2,000	$4,500	$2,000	$6,500
postage	$1,106	$0	$1,106	$0	$1,106
TOTAL	$5,006	$2,000	$7,006	$2,000	$9,006
Other					$0
Independent assessment	$0	$0	$0	$16,000	$16,000
Data processing	$0	$15,000	$15,000	$15,000	$30,000
SUBTOTAL	$321,486	$273,584	$595,069	$280,750	$875,819
Case mngmnt. fee			$1,346,571	$2,030,796	$3,377,367
TOTAL			$1,941,640	$2,311,546	$4,253,186

Note: For purposes of waiver, costs prior to waiver and for first year of waiver will be combined

APPENDIX D.1.

SOURCE OF ELIGIBILITY INFORMATION

In Montana, the primary system tracking eligibility is The Economic Assistance Management System (TEAMS). This is the source of the eligibility data throughout this waiver. TEAMS was developed over a two year period and started operating in 1991.

In February, 1992, the Administration for Children and Families of the U.S. Department of Health and Human Services (ACF/HHS) made an on-site inspection of TEAMS. The HHS Food Stamps program inspected the program in March, and the Health Care Finance Administration inspected it in April.

While a final determination on certification will not be available for a months, the Montana Department of Social and Rehabilitation Services is confident that it will be forthcoming. The initial ACF/HHS report noted that nothing in their review would preclude certification.

EXHIBIT #1

CALCULATION OF COSTS WITHOUT WAIVER

	Eligibles (1)	Total Eligible Months (2)
AFDC	5,536 (on 23 months)*	127,328
	27,293 (on 21 months)**	573,153
AFDC-related	1,982 (on 23 months)*	45,586
	11,046 (on 21 months)**	231,966
SSI	10,554 (on 14 months)***	128,756
	TOTAL:	1,125,789

*There will be two pilot counties in which AFDC and AFDC-related recipients will be mailed enrollment packets starting October 1, 1992. They will be enrolled and start participating by November, 1992.
**Enrollment packets will be sent to the remaining AFDC and AFDC-related recipients starting December 1, 1992. They will be enrolled and participating by January, 1993.
***SSI recipients will be enrolled starting July, 1993 and start participating August, 1993.

NUMBER OF ELIGIBLES BY WAIVER YEARS

22-Jun-92

Note: assumes pilot counties enroll starting 10/92, start participating 11/92; statewide enrollment starting 12/92, statewide participation starting 1/93; SSI enroll starting 7/93; start participating 8/93

	Eligibles	First Year of Waiver		Second Year ofWaiver		Total for Waiver	
		# Mos.	Elig. Mos.	# Mos.	Elig. Mos.	# Mos.	Elig. Mos.
Missoula							
AFDC	3,659	11	40,249	12	43,908	23	84,157
AFDC-rel.	1,371	11	15,081	12	16,452	23	31,533
Silver Bow							
AFDC	1,877	11	20,647	12	22,524	23	43,171
AFDC-rel.	611	11	6,721	12	7,332	23	14,053
Statewide							
AFDC	27,293	9	245,637	12	327,516	21	573,153
AFDC-rel.	11,046	9	99,414	12	132,552	21	231,966
SSI	10,554	2	21,108	12	126,648	14	147,756
TOTAL:	56,411		448,857		676,932		1,125,789

Monthly Case Management Fee:	$3	$3
Total Case Management Fee:	$1,346,571	$2,030,796

TOTAL ELIGIBLE MONTHS
FOR TWO-YEAR WAIVER PERIOD 1,125,789

Monthly Case Management Fee: $3

TOTAL CASE MANAGEMENT FEE
FOR TWO-YEAR WAIVER PERIOD: $3,377,367

CALCULATIONS OF COSTS WITHOUT THE WAIVER

Exhibit 1

Eligibility Category	SFY93 – Projected					
	Physician	Inpatient	Outpatient	Pharmacy	Lab & X-ray	TOTAL SFY93
AFDC Total (1)	$20,557,953	$41,045,699	$11,233,004	$4,584,533	$254,813	$77,676,002
% to Med. Ndy (2)	6.00%	8.20%	7.40%	21.40%	8.40%	
Subtotal	$19,324,476	$37,679,952	$10,401,762	$3,603,443	$233,409	$71,243,041
16% on 8 mos. (3)	$2,061,277	$4,019,195	$1,109,521	$384,367	$24,897	$7,599,258
84% on 6 mos. (4)	$8,116,280	$15,825,580	$4,368,740	$1,513,446	$98,032	$29,922,077
TOTAL AFDC SFY93	$10,177,557	$19,844,775	$5,478,261	$1,897,813	$122,929	$37,521,335
Total Medicaid	$28,772,124	$66,656,844	$19,239,208	$20,142,534	$535,154	$135,345,864
30.24% to SSI (5)	$8,700,690	$20,157,030	$5,817,936	$6,091,102	$161,831	$40,928,589

Note:
(1) budget for AFDC and AFDC-related (including medically needy)
(2) medically needy will not be on PASSPORT, so their costs must be subtracted
(3) pilot counties have 16% of the target AFDC and AFDC-related population;
assumes it will take one month to enroll recipients
(4) rest of the target AFDC and AFDC-related population will be enrolled two months later
(5) SSI recipients targeted for PASSPORT use 30.24% of total Medicaid costs for these five services;
assumes percentage of use consistent across categories of service
(6) cost data from "Medicaid Primary Care Projections for FY92 and FY93," attached
data not broken down by age, sex, or subgroups within SSI and AFDC
7) Rate of change based on document in Note #1; based on 4 year average rate of change
8) Base costs calculated on State Fiscal Years (SFY), i.e. from July to June
9) Costs then converted to waiver year costs, below

RATE OF CHANGE:	Physician	Inpatient	Outpatient	Pharmacy	Lab & X-ray
AFDC	1.1056	1.1181	1.197	1.0658	1.187
Total Medicaid	1.1241	1.1379	1.2033	1.0496	1.187

Eligibility Category	SFY94 – Projected					
	Physician	Inpatient	Outpatient	Pharmacy	Lab & X–ray	TOTAL SFY94
AFDC Total	$22,728,873	$45,893,196	$13,445,906	$4,886,195	$302,463	$87,256,633
% to Med. Ndy	6.00%	8.20%	7.40%	21.40%	8.40%	
TOTAL AFDC SFY94	$21,365,140	$42,129,954	$12,450,909	$3,840,549	$277,056	$80,063,609
Total Medicaid	$32,342,745	$75,848,823	$23,150,539	$21,141,604	$635,228	$153,118,938
30.24% on 11 mos.	$8,965,409	$21,025,294	$6,417,329	$5,860,453	$176,085	$42,444,570

Eligibility Category	SFY95 – Projected					
	Physician	Inpatient	Outpatient	Pharmacy	Lab & X–ray	TOTAL SFY95
AFDC Total	$25,129,042	$51,313,183	$16,094,749	$5,207,707	$359,024	$98,103,704
% to Med. Ndy	6.00%	8.20%	7.40%	21.40%	8.40%	
Total for SFY95	$23,621,299	$47,105,502	$14,903,738	$4,093,258	$328,866	$90,052,662
Total Medicaid	$36,356,479	$86,308,375	$27,857,044	$22,190,227	$754,015	$173,466,141
30.24% to SSI	$10,994,199	$26,099,653	$8,423,970	$6,710,325	$228,014	$52,456,161

CONVERTING STATE FISCAL YEAR COSTS TO COSTS PER WAIVER YEAR

Eligibility Category	First Year of Waiver Period (Oct 92 – Sep 93) Physician	Inpatient	Outpatient	Pharmacy	Lab & X-ray	TOTAL 1st YR
AFDC						
SFY93	$10,177,557	$19,844,775	$5,478,261	$1,897,813	$122,929	$37,521,335
On 3 mos. SFY94	$5,341,285	$10,532,488	$3,112,727	$960,137	$69,264	$20,015,902
SSI						
Not on SFY93	$0	$0	$0	$0	$0	$0
On 2 mos. SFY94	$1,630,074	$3,822,781	$1,166,787	$1,065,537	$32,015	$7,717,194
TOTAL 1st YR	$17,148,917	$34,200,044	$9,757,776	$3,923,487	$224,208	$65,254,432

Eligibility Category	Second Year of Waiver Period (Oct 93 – Sep 94) Physician	Inpatient	Outpatient	Pharmacy	Lab & X-ray	TOTAL 2nd YR
AFDC						
On 9 mos. SFY94	$16,023,855	$31,597,465	$9,338,182	$2,880,412	$207,792	$60,047,707
On 3 mos. SFY95	$5,905,325	$11,776,375	$3,725,934	$1,023,314	$82,216	$22,513,165
SSI						
On 9 mos. SFY94	$7,335,334	$17,202,513	$5,250,542	$4,794,916	$144,070	$34,727,375
On 3 mos. SFY95	$2,748,550	$6,524,913	$2,105,992	$1,677,581	$57,004	$13,114,040
TOTAL 2nd YR	$32,013,064	$67,101,267	$20,420,651	$10,376,223	$491,082	$130,402,287

TOTAL FOR WAIVER	$49,161,981	$101,301,311	$30,178,426	$14,299,711	$715,290	$195,656,719

Column Explanations for Exhibit 1

1. The TEAMS (The Economic Assistance Managaement System), the eligiblity tracking system for Montana, indicated that this was the total number of AFDC and SSI eligibles by in the previous year (please see APPENDIX D.1.).

2. The total eligible months was derived from the State's eligibilty information system (TEAMS) for the previous fiscal year (1991) to the waiver period (please see APPENDIX D.1.).

3., 4., 5., 6., 7.
The (Medical Information System) MIS disclosed that the costs in Exhibit 1 were incurred by the State during the base year period for providing all medical service categories to the total person eligible months noted in column (2).

8. Cost for all State plan major services to be covered under the waiver program, based on actual incurred costs for the base year.

9. Base year total costs were obtained from column (8).

10. New policies adopted by the State after the base year affected utilization rates as follows:

    a. _____ Inpatient rates will decrease as a result of the implementation of a DRG-based prospective payment system and lower average length of stays;

    b. _____ Outpatient utilization will increase due to an expanded ambulatory surgery program;

    c. _____ All other services utilization will increase due to increased family planning services; and

    d. _____ Other utilization will increase/decrease.

11. FFS price adjustments implemented by the State since the base year period resulted in the following:

a. _____ Inpatient hospital service costs are expected to increase due to an increase in room and board rates.

b. _____ Outpatient hospital service costs are expected to increase based on the annual CPI adjusted inflation factor.

c. _____ All other service costs are expected to increase due to fee schedule increases for primary care services.

d. __X__ Other: physician fees for specific pediatric and obstetrical services were raised October, 1991. This adjustment is included in the projections for SFY93 found in "Medicaid Primary Care Projection for FY92 and FY93."

12. During the base year period, the State did not exclude TPL recoveries for FFS inpatient hospital service costs. Since the total amount of TPL recoveries was $_____, this represented _____ percent ($_____ recoveries divided by $_____ total inpatient costs) of total inpatient costs. Therefore, _____percent is posted under column 12 for inpatient services and is a negative adjustment.

13. Other policy factors which affected the base year period costs were as follows:

a. _____ An increase in inpatient service costs will occur due to the implementation of a pre-admission review program for non-emergency inpatient admissions;

b. _____ A decrease in outpatient service is expected to occur due to the elimination of physical therapy coverage;

c. _____ A decrease in all other services is expected due to State elimination of AFDC subsidy for public transportation fares.

d. _____ An increase in clinic service costs is expected after April 1, 1990, when section 6404 of the Omnibus Budget Reconciliation Act of 1989 and section 4704 of the Omnibus Budget Reconciliation Act of 1990 are implemented. This establishes a new clinic type of federally qualified health center (FQHC). Reimbursement of FQHCs was increased to 100 percent of the reasonable costs of providing services to Medicaid recipients. Community health centers and certain other Medicaid clinic providers are being redesigned as FQHCs.

e. _____ Additional increase(s)/decrease(s) should occur.

14. Total projected costs are determined by multiplying the base year period costs (column 9) by the percentage adjustment factors in columns 10, 11, 12, and 13.